HEALTH INSURANCE GUIDE

IMPORTANT! *Some employer or employee groups purchase health insurance coverage from an insurance company. Others may purchase group health coverage from a health maintenance organization (HMO). Both are called fully insured health benefit plans. Insurers of such plans are regulated by the Tennessee Department of Commerce & Insurance (TDCI).*

Other employer or employee groups, however, provide what are called self-funded health benefit plans. This means your employer or employee group may set aside funds and employee premiums each month to pay health coverage claims submitted to the plan.

Sometimes self-funded plans are assumed to be fully insured plans because employers or employee groups hire an insurance company, HMO or third party administrator (TPA) to coordinate providers and handle claims and paperwork. With self-funded plans, the plan (or employer) assumes the risk (financial responsibility) of providing benefits and paying the claims.

States are not permitted to regulate most valid self-funded ERISA plans authorized by Congress under terms of the Employee Retirement Income Security Act ERISA . TDCI does not have regulatory authority over bona fide single employer or union self-funded plans established under ERISA. That authority belongs to the Department of Labor . This means in most cases:

Tennessee Department of Commerce & Insurance has no authority to investigate complaints that involved valid single-employer or union-sponsored self-funded ERISA plans. However, Commerce & Insurance has some limited authority to investigate complaints involving Third Party Administrators that exclusively administer valid ERISA plans.
State laws requiring specific benefits in health care plans seldom apply to valid self-funded ERISA plans.
Certain other group health plans provided by governments, churches, some school districts and out-of-state Blue Cross organizations also are exempt from most state regulations.

Much of the information provided at this site does NOT apply to self-funded plans. It applies mainly to fully funded or fully insured health plans where the risk is assumed by an insurance company or HMO.

To understand and protect your rights, regardless of what type of plan you may have, TDCI urges you to:

- Ask your employer whether the plan is fully insured or self-funded. It may not be obvious from your plan's benefit booklet.
- Read the benefit booklet carefully. Understand what is and is not covered.
- Follow all procedures and deadlines for seeking treatment and filing claims, complaints and appeals.
- Take complaints and appeals to the person or office authorized in your benefit booklet and other plan documents.
- If the plan is fully funded, take any unresolved complaints to TDCI.
- If the plan is self-funded and offered by a private sector employer or bona fide union, take unresolved complaints to the U.S. DEPARTMENT OF LABOR's (DOL) PENSION AND WELFARE BENEFITS ADMINISTRATION.
- Department of Labor does not interpret provisions of any particular health benefit plan or require employers to pay claims, but may investigate your complaint. In certain disputes, DOL suggests personal legal advice may be your only option.

- If the plan is self-funded but offered through a government or church employer, follow the appeals procedures outlined in your benefit booklet and other plan documents. In most cases ultimate responsibility for resolving disputes rests with the governing body of the employer sponsoring the plan.
- If you have a disability, you may have certain protections available under the Americans with Disabilities Act (ADA) if your self-funded coverage is dropped or limited. You can reach the ADA Technical Assistance Center at 1-800-949-4232, or the U.S. Department of Justice at 1-800-514-0301 (voice) or 1-800-514-0383 (TDD).

YOUR HEALTH BENEFIT PLAN QUESTIONS

Benefit Plan Basics

1. WHAT KIND OF COVERAGE IS AVAILABLE?

In general, two types of coverage-traditional insurance plans and managed care plans-may be available to you as an individual or as a member of an employer or association group health plan. Managed care plans include preferred provider organization (PPO) plans and health maintenance organization (HMO) plans.

Insurance (also indemnity or fee-for-service) plans allow you to go to any physician you choose but require that you pay for the services and file (or allow your physician or provider to file) claims for reimbursement. The most common fee-for-service plans cover comprehensive health services.

Managed care plans use networks of selected doctors and other providers to provide comprehensive health services. They may require that you use the plan's providers or they may offer incentives to encourage their use.

Preferred provider organization (PPO) plans issued by an insurance company are insurance plans that provide higher reimbursements if you go to PPO network physicians, providers and hospitals that provide services to health plans for discounted fees. You choose your personal doctor and do not need a referral to see a specialist.

Health maintenance organization (HMO) plans typically require that you use network physicians, hospitals and other health care providers. Your personal gatekeeper physician also must provide a referral if you want to go to a specialist or outside the HMO's network for treatment. HMO's also eliminate the need to file claims. Members prepay for their health care through monthly premiums and co-payments made as services are delivered. HMO's may pay providers a set fee, called a capitation fee, for each health plan member, regardless of the amount of services performed.

Point-of-service (POS) plans or wrap plans may be available with some HMO's. They give HMO enrollees the option of receiving services outside the HMO's network without prior approval from a network physician. Inside the network, the plan operates like an HMO. Outside the network, it operates like a traditional insurance plan.

WITH AN INSURANCE PLAN OR PPO PLAN:

YOU PAY:

Premiums-the monthly amount you pay for insurance coverage.
Deductibles-the amount of covered expenses you pay each year before the policy begins to pay.
Co-Insurance-your share of each covered expense. It is a percentage calculated on the cost of a service.
Out-of-pocket limit-the maximum you pay in one year when you combine your required deductible and co-insurance. Co-payment-the amount you pay when you receive medical care (usually found in a PPO plan).

THE PLAN PAYS:

Lifetime maximums-the maximum amount, such as $1 million, that the insurance company will pay in your lifetime toward your total medical expenses or toward certain benefits.
Co-Insurance-the company's share of each covered expense, such as 80 percent of the usual and customary charge.

100 percent payment-the amount the company will pay on covered expenses when you reach the annual out-of-pocket limit for your plan. Payments continue until the policy's maximum limits are reached or until the end of the year.

Discount fees- for service to providers-Insurance companies often negotiate discounted fees with health providers (found in a PPO plan).

WITH AN HMO

YOU PAY:
Premiums-the monthly amount you pay for coverage.
Co-payment-the amount you pay when you receive medical care or a prescription not fully prepaid. Co-payments usually refer to the set amount you owe for service.

Deductibles-the amount of covered expenses some HMO plans may require you to pay each year before the plan begins to pay. (Most HMO plans, however, do not have deductibles.)

Maximum out-of-pocket expense-the maximum amount an individual covered under a health care plan must pay during a certain period for expenses covered by the plan. Until the maximum is reached, the covered individual is required to pay a co-payment.

THE PLAN PAYS:

Capitation to providers-a system where an HMO pays a doctor or hospital a flat monthly fee for the care of each health plan member whether or not any services are delivered. Not all providers receive capitation. Discount fees for service to providers-HMO's contract with health providers to provide services at discounted rates. 100 percent of the cost of all covered services in excess of the co-payments.

INDIVIDUAL HEALTH PLANS are offered by insurance companies. They may be a good option if you are self-employed or work for a company that does not offer a group health plan. Most individual policies are on a fee-for-service basis.

GROUP PLANS may be fully insured by insurance companies or HMO's, or they may be self-funded by employer contributions and employe premiums.

FULLY INSURED EMPLOYER GROUP PLANS are subject to state regulation. Certain laws apply depending on the number of eligible employees in the employer group. In general, individuals cannot be excluded from group plans for health reasons.

SMALL EMPLOYER GROUP PLANS are available to employers with two (2) to 50 eligible employees. Special provisions may apply, including certain eligibility, participation and contribution requirements. Unlike large employer group plans, certain rate restrictions apply. For example, with groups of 3 - 25 employees coverage must be offered to all eligible employees and dependents and coverage of the group is guaranteed renewable, except in certain cases, such as when premiums are not paid or policy terms are violated.

TIP - In many cases, group plans provide more coverage and cost less than individual policies. The idea behind group coverage is to spread the risk of claims over a large number of people, resulting in lower rates. A group plan also may offer more benefits and greater accessibility, especially for people with health problems.

Large employer group plans are available to those with more than 50 eligible employees. Special provisions apply, including certain eligibility, participation and contribution requirements. Dependent coverage is not required to be offered.

Valid self-funded ERISA plans are funded strictly from employer contributions and employee premiums. With self-funded plans, the plan itself assumes the risk of providing benefits and paying the claims. Such plans come under the jurisdiction of the U.S. Department of Labor (DOL).

Association group plans are those fully insured plans issued to participating employee groups, including those formed by labor unions, nonprofit membership corporations, and individuals who are members of the association.

Types of Individual Health Policies

Major Medical Health care policies that usually cover both hospital stays and physician's services in and out of the hospital.

Hospital-Surgical Policies that cover only expenses directly related to hospital and surgical services, such as daily room, surgery and doctor charges.

Hospital Indemnity Policies that pay a fixed amount each day you are in the hospital.

HMO Pays for a wide range of medical service as long as you use the plan's doctors and facilities. Also covers preventive care, often not included in major medical policies.

Specified or Dread Disease Policies that pay only if you contract the illness specified in the policy, such as cancer or AIDS. Pays in addition to other insurance.

Short-Term Coverage that lasts only for a specified length of time.

2. DO EMPLOYERS HAVE TO PROVIDE HEALTH CARE COVERAGE?

No. If a business does not offer health care coverage, certain state and federal regulations may apply. Even if health benefits are offered, certain requirements, such as full-time status, may be imposed and the employer may impose a waiting period for all new employees before coverage is effective.

Eligible employees for small and large employer plans:

Usually work at least 30 hours a week.
Do not have coverage under another group health benefit plan.
Are not classified as temporary or seasonal workers.
A count of eligible employees is used to determine whether a firm is a small employer or a large employer. This is not based upon the number of employees insured.

3. MUST INSURANCE COMPANIES AND HMOS ACCEPT EVERYONE?

It depends. Insurance companies and HMO's do not have to accept everyone who applies for an individual policy.

With small employer health plans, state and federal laws now provide guaranteed issue protection. That means if an insurance company or HMO sells small employer group coverage, it may not refuse to cover a group, even if one or more employees or their dependents have health problems. Under small employer plans, all eligible employees, and their dependents, must be offered coverage. In addition, individuals cannot be excluded for health reasons. Health status may be screened, but only to determine the appropriate premium rates for the group.

Employers are permitted to determine which class of employees (if any) is offered a health plan. For example, employers are free to offer health plans to certain classes of employees, such as executive employees only. Once an insurance company or HMO offers a health plan to a employer, it may not exclude any individual employee in the class of employees covered simply because he or she has health problems. This applies to both insured employer plans and valid self-funded ERISA plans. All such plans offered through insurance companies and HMO's must accept all qualified employees or none. The health history of individuals in the group may be screened, but only to determine whether to accept or reject the entire group or what group premium to charge.

4. WHAT IF I'VE HAD A MEDICAL PROBLEM?

With an individual policy, you may be:

Required to undergo a physical or a health screening.
Refused individual coverage based on your medical history.

Offered individual coverage with a rider that excludes coverage of your medical problem for a specified amount of time or indefinitely.

Given a pre-existing period for up to two (2) years. With an employer group policy, you may be required to:

- Wait up to 12 months before receiving benefit payments for any pre-existing medical condition.
- Complete an HMO affiliation period of up to two months if you are a new enrollee, as long as the requirement is applied uniformly and is not based on health status. Late enrollees may have to wait up to 90 days. During the affiliation period, premiums are not collected and coverage is not provided. If an employer imposes a waiting period, an HMO affiliation period will run concurrently.

PORTABILITY PROVISION

Although new state and federal laws provide certain portability provisions, they do not allow you to keep your current health plan when you change jobs. Portability means workers with pre-existing medical conditions must receive credit for time in a previous health plan if they join an employer plan that started or renewed on or after July 1, 1997.

If you change jobs, the pre-existing condition exclusion for any new employer health plan is reduced by one month for every month covered under your old plan. Federal law provides credit only as long as the break in health coverage is no more than 63 days.

TIP-If you move from a group, government or church health plan to an individual health policy and if you exhaust your COBRA or state continuation (or it not available) you are considered an eligible individual. As an eligible individual you will have no pre-existing condition waiting period. You must apply before the 64th day to avoid a gap in coverage. If you have less than 18 months, or a gap of more than 63 days, you will not be an eligible individual.

5. WHAT CAN I DO IF I'M REFUSED INDIVIDUAL COVERAGE?

If you are refused coverage:

- Find out why you were denied coverage. If denied because of your medical history, you may want to verify that the information is correct.
- Try other insurance companies.
- Check state and national non-profit groups that help those with a similar health problem.
- Try business, professional or other associations that offer group health care coverage to members.
- Seek coverage from TennCare, Medicare or other government programs.

IMPORTANT

Once a policy is issued, it may not deny, limit, cancel, refuse to renew, charge individuals different rates for the same coverage or otherwise adversely affect coverage or eligibility of coverage using factors related to health status, such as medical condition (physical and mental), claims experience, receipt of health care, medical history, genetic information, evidence of insurability (including acts arising out of family violence) and disabilities.
TIP-To check your medical history, you may want to contact the Medical Information Bureau

(MIB). The MIB provides member companies with brief coded reports on the medical history of applicants. If you are denied coverage based on your medical history, you can contact MIB for more information at: 617-426-3660, or write to:

MIB
P.O. Box 105, Essex Station
Boston, MA 02112

PURCHASING HEALTH CARE COVERAGE

6. I'VE STARTED A NEW JOB. SHOULD I APPLY FOR EMPLOYER GROUP HEALTH COVERAGE RIGHT AWAY?

Yes. It's a good idea for everyone to have health coverage.

TIP - If you or a dependent are able to enroll after the employer's initial enrollment period, you are considered a late enrollee and may have to meet additional requirements before coverage can begin. As a result, you may be subject to an 18-month pre-existing condition limitation. If your employer has more than 50 employees, you may not be able to enroll at a later date unless you qualify for a special enrollment period.

7. I'M GOING AWAY TO COLLEGE SOON. WHAT SHOULD I DO ABOUT HEALTH COVERAGE?

In most cases, college students should stay on their parents' health plans as long as possible. In addition, you should:

Make sure you understand what is and is not covered by your health plan.

Know that if you stay on your parents' HMO coverage, you will have to travel back home to see your primary care physician for routine health care. Besides exceptions made for medical emergencies, check to see if your HMO has a division or reciprocal agreement with an HMO in the area where you are attending school. Before the need arises, ask your HMO about notification and other requirements for out-of-network emergency care.

Realize that health policies sold specifically for students can range from simple accident policies to those that cover major medical needs. Some schools also offer fee-based student health clinics that vary in the kinds of services and benefits provided. Such policies also may be limited to accidents, injuries or illnesses that occur during a specific semester or school year. Be sure you know when the policy is in force.

Understand that you could lose group plan coverage because of your age, drop below full-time status during a term and do not return to full-time status.

8. SHOULD I CHANGE INSURANCE COMPANIES OR HMO's TO LOWER MY PREMIUMS?

Don't switch just to save money. Premiums can rise, and cheap coverage can become expensive. Before changing coverage, get answers to these questions:

Will lower premiums mean fewer benefits?
In an individual plan, will a past or present health condition cause problems in finding other coverage?
In an individual plan, will your medical history result in restrictions in the new policy?
Will your present plan let you drop unneeded benefits or increase deductibles to reduce the premium?
Will you be allowed to add back benefits you've dropped?
TIP-If you are shopping for new individual or group health care coverage, be sure you:

Keep your present health care coverage until your new coverage is in effect. Most companies do not begin coverage until they approve your application and deliver your policy.
Shop around among agents and companies.
Contact your own doctor for comment.
Ask friends and family for recommendations.
When comparing prices, make sure you compare the same benefits.
Confirm that the health benefit plan covers all illnesses.
Buy one policy that provides the most coverage you can afford.
Check the insurance company's licensing status, financial strength and complaint history.

9. WHAT ADDITIONAL PRECAUTIONS SHOULD I TAKE WHEN I BUY HEALTH CARE COVERAGE?

When you apply for coverage, fill out the application accurately and completely. If you knowingly give incorrect or misleading information or fail to disclose relevant information, your coverage could be canceled or benefits denied. Never sign a blank application. Verify any information filled in by the agent. Make payments by check or money order payable to the insurance company or HMO, not to the agent. Insist on a signed receipt on the company's letterhead. Pay no more than two month's premium and fees until you have received the policy, group certificate or HMO subscriber certificate. Make sure you have the full name, address and phone number for both the agent and the insurance company or HMO.

TIP-In the case of individual HMO and individual insurance coverage, state law requires a 10-day free look. You can change your mind and receive a refund if you return the individual policy within the free-look period. That period starts when you receive the policy. If you return the policy, send it by certified mail, return receipt requested. That gives you a record of the return date in case a dispute arises. State law does not require a free-look period for group insurance or group HMO coverage.

TIP-Spend your health care dollars on one comprehensive major medical policy. Extra policies probably aren't necessary. If you need more coverage, some health plans allow you to add benefits. Other kinds of policies may cost less but they:

Usually provide fewer benefits.
Are too limited to be your sole health care coverage.
May duplicate coverage you already have.
Policies with restricted benefits include:

Policies that pay medical expenses ONLY in the case of accidents.
Hospital confinement policies that pay a certain amount per day while your are hospitalized.
Policies covering ONLY in-patient hospital care.
Specified disease policies that pay ONLY if you are hospitalized or treated for the specific disease named in the policy, such as cancer, heart disease or AIDS.

10. WHAT SHOULD I CONSIDER IN HELPING ME CHOOSE THE BEST HEALTH PLAN?

As you look at a new heath insurance policy or HMO health plan booklet, consider:

Costs-What is the plan's history of premium increases? What notice is required before a premium increase? How are deductible and out-of-pocket costs figured? What are the co-payment levels? When are they charged?
Restrictions-What are pre-existing condition requirements? Does the plan allow you to go to any physician? Is access to specialists restricted? How? Does the plan cover your choice of hospitals? Are out-patient/day-surgery procedures covered? Do certain benefits have limits per day or per treatment? Are the limits per person, family, illness, hospital confinement? What are the policy limits for daily hospital room and board? Medicine, tests or other hospital expenses? Specific types of surgery? Physicians' visits? Number of hospital days? Number of physicians' visits during a hospital stay? Number of visits for any particular benefit or service? Amounts paid for specialists, such as anesthesiologists? Are benefit paid even if you have other coverage? Does the plan have any lifetime maximums? What is the procedure for out-of-network emergency care? How long does it take to get an appointment to see your physician? Are there any limits on medicines, referrals to specialists or the types of tests or treatments available?

Benefits-Does the plan cover office visits? What illnesses or services are excluded? Are any long-term care benefits included? Is any important benefit missing? Can it be added? What are the benefits levels? What are the terms for out-of-network care? Are special services offered, such as well-baby and well-mother programs? What other preventive health care services are offered?

Other Considerations-Is the staff helpful and accessible? Do you understand the appeal process if you disagree over a claim or coverage question? Has the physician or hospital you want dropped off the plan within the last year?

TIP-If your current physician is not on the list of HMO network physicians, ask friends, local medical groups and the HMO for information to help you choose a primary care physician. HMO's usually use medical doctors specializing in family practice as primary care physicians.

11. WHAT SHOULD I EXPECT IN TERMS OF LONG-TERM CARE BENEFITS?

In general, Medicare, Medicare Supplement and other health care plans to not pay for the personal care you may need. Some may cover short-term skilled nursing home care, but long-term custodial care in a nursing home or custodial care at home usually require coverage under a long-term care policy.

TIP-Your health care coverage may not pay for services unless they are specifically named in the policy.

AMERICANS WITH DISABILITIES ACT (ADA)

You may have certain protections available under the Americans with Disabilities Act (ADA). You can reach the ADA Technical Assistance Center at 1-800-949-4232, or the U.S. Department of Justice at 1-800-514-0301 (voice) or 1-800-514-0383 (TDD).

12. WHAT SHOULD I KNOW ABOUT COVERAGE FOR AIDS OR HIV?

Insurance companies may limit the amount they will pay for AIDS-related medical expenses. Also keep in mind:

- An insurance company or HMO cannot cancel individual or group coverage solely because a person is diagnosed with AIDS or an HIV-related illness.
- An insurance company or HMO does not have to sell an individual policy to a person with AIDS or HIV.
- A large employer group also can be denied coverage for the entire group. In some cases, large employer groups are denied coverage when one member has AIDS.
- In small employer plans, the guaranteed issue requirement means a person who is HIV positive cannot be excluded from the group.

13. WHAT DOES THE LAW SAY ABOUT MATERNITY AND NEWBORN COVERAGE?

If your company has 15 or more employees, federal law requires that maternity benefits be included in your group health benefit plan. In addition, state OR federal law:

- Prohibits employer health plans from denying benefits because a pregnancy is determined to be a pre-existing condition.
- Requires that post-delivery care must be provided if a mother is discharged earlier than 48 hours after and uncomplicated vaginal delivery or 96 hours after an uncomplicated Cesarean birth. Such care must be at the mother's home, a health provider's office, a health care facility or "other location determined to be appropriate" by the Commissioner of Insurance.
- Requires newborn coverage for the first 31 days if the health care plan provides dependent coverage. The plan may not exclude or limit initial coverage of a child because of accident or illness-especially congenital medical conditions or premature birth. To continue newborn coverage beyond the first 31 days after

birth, notify the plan/company within the first month that you have a newborn and pay any additional required premiums.

CONSIDERATION OF DEPENDENTS

Birthday rule-If both parents have group plans and both cover dependents, the health benefit plan of the parent with the earlier birth date pays first. For example, the plan of the parent whose birthday is July 3 picks up the child's medical bills, rather than the parent whose birthday is July 4. (Calendar year)

Birthday rule and divorce-The birthday rule does not apply in divorces. The court usually determines which plan is primary. If it does not, coverage goes first to the parent with custody, second to the spouse of the parent with custody and third to the parent without custody.

Court-appointed conservator-Group health plans and HMO's may pay claims on behalf of a minor child (whose parent is a member of the group plan) to the child's court appointed conservator who is not a member of the group.

Court-ordered medical support-If a court orders medical support for a child, health plan enrollment and service are restrictions do not apply and coverage must be provided even though the child may live outside the service area.

These laws apply to group and individual coverage if maternity benefits are covered.

ELIGIBLE DEPENDENTS

Adopted children-Adopted children, including children you are seeking to adopt through the courts, may not be excluded from coverages if policies provide for your immediate family or children. Natural or adopted children of the spouse of the person insured must reside with the member of the group health plan.

Certain grandchildren-Health plans must cover grandchildren if they are dependents for federal income tax purposes. (Only if they have custody by court order)

Mentally/physically handicapped children-Health plan age limitations for dependents do not apply in cases where the child (minor or adult) is incapable of self-support due to mental retardation or physical handicap.

Newborn children-Policies that allow you to add dependents must provide automatic coverage for a newborn for the first 31 days and beyond if notification is given and the premium paid within the 31 days.

TIP-A state mandated benefit covering complications of pregnancy may help if your health plan does not include maternity benefits. A miscarriage and a non-elective Cesarean birth are considered complications of pregnancy; in most cases, management of a difficult birth is not. Management of a difficult birth is covered only if the health benefit plan includes maternity benefits.

YOUR HEALTH CARE COVERAGE PROBLEMS

Claims and Billing Problems

14. DOES MY HEALTH BENEFIT PLAN HAVE TO PAY CLAIMS PROMPTLY?

In general, licensed insurance companies and HMO's usually:

- Acknowledge receipt of your claim within 30 days after receiving it in writing. (Remember that pre-certification of a procedure or treatment is not the same as pre-approval of a claim payment.)
- Accept or reject your claim within 30 business days of receiving all required information. (The company may request additional information, including a signed claim, or proof-of-loss form, giving details about the medical service or treatment.)
- Send you notice explaining any delay.
- Give reasons in writing if they reject your claim.
- Make payment within five business days after sending notice that your claim will be paid.

TIP-If you are in a claims dispute, it sometimes helps to:

- Provide the insurer with additional details about your treatment, your condition and any special qualifications your provider might have.
- Ask the physician or provider to send a letter explaining anything unusual about the procedure or the amount charged.
- Make sure your physician or provider used the proper treatment or procedure code. An improper code may result in a claim being rejected or incorrectly paid.

TIP-Some physicians and providers bill patients when the patients' HMO is slow to reimburse them. The enrollee should notify the HMO and let the HMO handle payment.

15. DO I GET AN EXPLANATION IF THE INSURER REFUSES TO PAY MY CLAIM?

Yes. You must receive a written explanation. If you are not satisfied, you should:

Ask to see the policy language backing up denial of your claim.
If your plan is fully insured, file a complaint with the insurance company, HMO or TDCI.
Important-It's unlikely any health benefit plan will pay 100 percent of your bill.

Your settlement may be reduced by any of the following:

Deductibles-That portion of your medical bills not reimbursed by the insurance company. Common deductibles include $200 and $500 per person per year.

Co-payments-A partial payment for health services, paid to the provider at the time you receive the services.

Co-insurance-A percentage of each health care bill you must pay, including any non-covered charges and deductibles. An example of co-insurance is an 80/20 split of approved charges, with you paying 20 percent. The 80 percent is the insurance company's share of the bill.

Fees that exceed usual and customary charges (unless the provider is under contract with the health plan to accept the usual and customary charges or other negotiated fees.) HMO enrollees usually don't have to worry about deductibles, co-insurance or usual and customary charges, only their co-payments.

Definition: Usual and Customary Charges

Typical amounts charged by providers for everything from a doctor's office visit to heart surgery. Health benefit plans commonly will not pay full benefits if the fees billed by a physician or provider are higher than those charged by other physicians and providers in your are. Usual and customary charges may be based on:

- Typical fees charged by physicians and providers in your area;
- Typical fees compiled by independent rating services; or typical fees compiled by the insurance company/third party administrator.

TIP-To limit the chances of a claim dispute:

- Study provisions of your health benefit plan and understand any limitations or exclusions before seeking medical treatment. Your health benefit plan covers only the medical care specifically described in the policy or HMO contract. Be sure all benefits described to you by an agent or others are in the written policy. Determine whether pre-certification for certain non-emergency medical care or procedures is required. Failure to get pre-certification could reduce benefits. Pre-certification does not guarantee claim payment. The health plan decides whether it will pay a claim after receiving all necessary documents and reviewing its contract with the policyholder.
- Notify the HMO/Insurance company within the required time period if admitted to a hospital under emergency conditions.

16. WHAT SHOULD I DO IF MY CLAIM IS REJECTED OR I'M NOT REIMBURSED PROPERLY?

The majority of insurance companies maintain a toll-free telephone information and complaint line, and some companies and HMO's provide special mediation or arbitration procedures for handling complaints. Here are a few suggestions for handling claim or reimbursement problems:

- For group coverage, contact your group health benefit plan benefits administrator, if one is available. If there is no benefits administrator or if you have an individual health care policy, you should contact the insurance company.
- Submit a written complaint to your health benefit plan, insurance company or HMO specifying your concerns.
  Ask for explanations in writing and keep good records, including the names of people you talk to while trying to resolve the matter.
- Ask your health benefit plan to verify that your share of the bill (co-insurance or HMO co-payments) was based on the actual bill the insurance company paid AFTER any negotiated discount arrangement. An insurance company or HMO that refuses to base your share of the bill on actual billings is engaging in a prohibited and unfair claim settlement practice.

- If you do not resolve the matter, file a formal complaint with TDCI.
  TIP-TDCI is the chief agency charged with investigating a wide range of complaints against insurance companies and HMO's.

17. HOW CAN I FILE A FORMAL COMPLAINT WITH TDCI?

No special form is needed to file a formal complaint. You may simply write a letter and include the information as outlined below, or to request a complaint form, please call Consumer Insurance Services at 1-800-342-4029. Send your complaint letter or completed complaint form to:

Tennessee Department of Commerce & Insurance
Consumer Insurance Services
500 James Robertson Pkwy, 4th Floor
Nashville, TN 37243-0295

Please include a complete description of your complaint, along with the following:

- Names of family members insured under your health care plan.
  Your name and address.
- The full name of the insurance company or HMO.
- The full name of the insurance agent.
- Your policy number.
- A concise but complete description of your complaint and the date of your disputed health care service.
  Copies (not originals) of any supporting documents, including letters, notes, invoices, canceled checks or advertising material.
- A copy (not originals) of policy language involved in the dispute.
- When you file a complaint with TDCI we will acknowledge your letter. A complaint investigator will work to resolve the complaint within the limits of the TDCI authority and keep you informed of its status.

Important-If a company insists your complaint or claim is not valid, TDCI cannot compel payment except in cases where state insurance law is clearly violated. In some cases, mediation or legal action is necessary to resolve a dispute over fact issues and legal obligations. You may want to talk to a mediator, lawyer, the Legal Aid Society or other organization if your complaint cannot be resolved and it involves a significant amount of money. State law prohibits TDCI from providing legal advice or opinions or acting as your private attorney.

18. MY HEALTH CARE COVERAGE PREMIUMS KEEP GOING UP. WHAT CAN I DO?

Most states do not have authority to set or disapprove rates for health care coverage premiums. Each insurance company, HMO or other health plan sets its own rates. (Certain restrictions are placed on plans issued to small employers, however.) In general, rates for health care coverage may vary depending on:

- The geographic location.
- The kinds and amounts of benefits paid.
- The amount of any deductibles.
- The number of covered dependents.

- The claims experience of its customers.
- Regulated insurance companies and HMO's must give 30 days' notice to group policyholders before increasing group coverage premiums. (The group policyholder, in many cases, is your employer.)

If your premiums are rising, re-examine current benefit levels and ask your insurance company or HMO to negotiate changes that will lower your premium or minimize any increase. Some companies negotiate and some do not. If the company will negotiate, you may be able to revise your benefit package to reduce the premium. Be careful not to give up an essential benefit. Options for negotiations might include:

1. paying a higher deductible and/or co-payment
2. increasing your maximum out-of-pocket payment
3. reducing or limiting a medical benefit or accepting pre-certification before costly medical procedures are allowed.

If you are concerned about the size of certain physician fees and hospital charges 1) check with your health benefit plan to see if the provider's estimate of how much the treatment will cost is within the usual and customary range; 2) keep a record of whom you talk to and when; 3) then get a second opinion if surgery is involved.

Also, don't be afraid to challenge a physician or provider about the costs of tests or services.

Request an itemized bill and review it. Question billings you do not understand. If the explanation doesn't make sense, check with your health benefit plan.
Check whether your physician or provider included the proper treatment or procedure code. An improper code may result in the wrong benefit being listed.
Tell your insurance company or health benefit plan administrator if you think certain charges are incorrect or you were charged for a service never received.

LOSS OF HEALTH CARE COVERAGE

19. WHAT SHOULD I KNOW IF I LOSE MY HEALTH CARE COVERAGE?

COBRA Protection- Protection also may be available under a federal law called COBRA. (Consolidated Omnibus Budget Reconciliation Act). COBRA gives employees, or in some cases retired employees, the right to continue group health care coverage for a period of 18 months for themselves and up to 36 months for spouses and any dependent children if the employer 1) loses coverage because of reduced work hours or 2) loses the job for reasons other than gross misconduct.

COBRA applies to all employer health benefit plans with 20 or more employees, except plans sponsored by the federal government and certain church-related organizations.

COBRA also enables a spouse and dependent children to continue coverage when an employee is entitled to Medicare, divorces or dies. An employee's children qualify for continued coverage under COBRA if they lose dependent child status under the rules of the health benefit plan. An employee, spouse, or dependent child has 60 days after qualifying for COBRA coverage to decide whether to take it. If accepted, the cost to the employee, spouse or dependent child is the full premium, plus a 2 percent administrative fee. Depending on the situation, coverage may continue for 18 to 36 months. (Slightly longer in some situations.)

BASIC HEALTH COVERAGE TERMS

Accident only policies
Policies that pay only in cases arising from an accident or injury.

Capitation
A system where an HMO pays a doctor or hospital a flat monthly fee for the care of each health plan member whether or not any services are delivered.

Certificates of Coverage
Printed material showing members of a group health benefit plan the benefits provided by the group master policy.

Closed practice
A primary care physician who is not accepting new patients. Note: Even if your physician is on the HMO or PPO list, call to see if the practice is still open for accepting new HMO or PPO participants.

Complaints
A complaint is a written grievance.

Co-Insurance
The percentage of each health care bill you must pay out of your own pocket, including any non-covered charges and deductibles. Does not usually apply to HMO coverage.

Coordination of benefits
A provision allowing group plans to coordinate payments to make sure payment is not made for more than 100 percent of your medical expenses.

Co-payment
The amount you must pay when you receive medical care or a prescription not fully prepaid. Co-payments usually refer to set fees HMO's charge but also may apply to a PPO insurance contract.

Deductible
The amount you must pay before the insurance company/HMO begins to pay its portion of claims.

Disability benefits
Insurance company coverage providing protection against loss of wages due to illness or injury.

Eligible employee
An employee who works on a full-time basis and who usually works at least 30 hours a week. Eligible employee does not include someone covered under another health plan or who works part-time.

Emergency care
Health care services provided in a hospital emergency facility or comparable facility to evaluate and stabilize sudden and severe medical conditions.

Employers' self-funded ERISA health benefit plan
A health plan where claims are paid strictly from employer contributions and employee premiums.

Evidence of Insurability
Proof that you are in good health.

Exclusions or limitations
Provisions that exclude or limit coverage of certain named diseases, medical conditions or services, as well as some sicknesses or accidents that occur under specified circumstances.

Fee for Service
A health plan that allows you to go to any physician you choose, but requires that you pay for the services yourself and file claims for reimbursement. (Also known as an indemnity insurance plan.)

Gatekeeper--See Primary care physician.

Grievance Procedure
The required appeal process an HMO provides for you to protest a decision regarding medical necessity, claim payment, contract language or delivery of health care. Insurance companies also may have grievance procedures.

Guaranteed renewable
Such policies may be non-renewed or canceled only in certain cases. An insurer may cancel your policy for failure to pay premiums, fraud or intentional material misrepresentation. It also may cancel your policy if the company formally leaves the individual, small employer group or large employer group health market.

Health benefit plan
In most cases, health care services provided to employees by an employer. It can be an indemnity plan or an HMO plan.

Health maintenance organizations (HMO)
A managed care system that provides services to members through a network of physicians, hospitals and other health care providers. HMO's eliminate the need to file claims in most cases by allowing members to prepay through monthly premiums and co-payments made as services are delivered.

Hospital indemnity policies
Policies that pay a fixed amount each day you are in the hospital without regard to cost.

Hospital-surgical policies
Insurance policies that cover hospital and surgical services only.

Indemnity or Insurance plan
A health plan that allows you to go to any physician you choose, but requires that you pay for the services yourself and file claims for reimbursement. (Also known as fee-for-service.)

Inpatient medical care
Medical and surgical care usually received in a hospital or skilled nursing home environment.

Lifetime maximum
Total benefits a health care plan will pay over a policyholder's lifetime.

Long-term care benefits
Coverage that provides help for people when they are unable to care for themselves because of prolonged illness or disability. Benefits are triggered by specific findings of cognitive impairment or functional incapacity. Benefits can range from help with daily activities while recuperating at home to skilled nursing care provided in a nursing home.

Major medical policies
Health care policies that usually cover both hospital stays and physicians' services in and out of the hospital.

Managed health care
A system that organizes physicians, hospitals, and other health care providers into networks with the goal of lowering costs while still providing appropriate medical services. Many managed care systems focus on preventive care and case management to avoid treating more costly illnesses.

Mandated benefits
Health care benefits that state or federal law says must be included in health care plans.

Mandated offerings
Health care benefits that must be offered to the employer or organization sponsoring a group policy. The sponsor is not required to include the benefits in its group plan.

Maximum out-of-pocket expense
The maximum amount an individual covered under a health care plan must pay during a certain period for expenses covered by the plan. Until the maximum is reached, the covered individual is required to pay a co-payment or percentage on each claim.

Medical reimbursement accounts
Although not an insurance benefit, (sometimes referred to as a flexible benefits plan) such accounts allow you to set aside pre-tax dollars to pay for medical care or medical costs not covered by your regular health benefit plan.

Medically necessary care
Health care that results from illness or injury or is otherwise authorized by the health care plan. This term can be defined differently from one health care plan to another.

Multiple employer plans
Benefit plans that serve employees of more than one employer and are set up under terms of a collective bargaining agreement.

Network
All physicians, specialists, hospitals and other providers who have agreed to provide medical care to HMO members under terms of the contract with the HMO. Insurance contracts with preferred provider (PPO) benefits also use networks.

Non-contract or non-network providers
Those health care practitioners and treatment facilities not under contract with the HMO or those that do not have an insurance PPO contract.

Out-of-area
The area outside the counties or ZIP codes in which your HMO or PPO provides regular and preventive coverage.

Outpatient services
Services usually provided in clinics, physician or provider offices, hospital-based outpatient departments, home health services, ambulatory surgical centers, hospices and kidney dialysis centers.

Point-of-Service (POS) plans
POS or wrap plans allow an HMO to contract with an insurance company to give enrollees the option of receiving services outside the HMO's network.

Pre-certification
A requirement that the health care plan must approve, in advance, certain medical procedures. Pre-certification means the procedure is approved as medically necessary, not approved for payment.

Pre-existing condition
A medical problem or illness you had before applying for health care coverage.

Preferred provider organization (PPO)
A type of plan in which physicians, providers and hospitals agree to discount rates for an insurance company. Insurance contracts with PPO provisions reimburse at a higher percentage if you go to physicians, providers and hospitals giving discounts.

Premium
The fee you pay for health benefit plan coverage.

Primary care physician (gatekeeper)
The physician selected by HMO members to serve as their personal doctor and provide all basic medical treatments and any referrals to medical specialists.

Provider
A hospital, pharmacist, registered nurse, organization, institution or person licensed to provide health care services in Tennessee. A physician also may be referred to as a provider.

Provider network
All the doctors, specialists, hospitals and other providers who agree to provide medical care to HMO or PPO members under terms of a contract with the HMO or insurance company.

Self-funded ERISA health benefit plans
Plans funded strictly from employer contributions and employee premiums. State regulations of such plans is limited. Although an insurance company may be hired to administer the plan, the insurance company assumes no risk.

Service-area
The counties, or portions of counties, where an HMO or PPO provides coverage.

Skilled Nursing Care
Care needed after a serious illness. It is available 24 hours a day from skilled medical personnel such as registered nurses or professional therapists. A doctor orders skilled nursing care as part of a treatment plan.

Specified disease policies
Policies that pay only if you contract the illness specified in the policy.

Specified medical limitations
A dollar limit placed on treatment of certain medical conditions or types of treatment.

Underwriting
The process insurance companies use to examine, accept, reject and classify the risks associated with an applicant for coverage.

Utilization review
The review process aimed at helping HMO's and insurance companies reduce health care costs by avoiding unnecessary care. The review includes evaluating requests for medical treatment and determining, on a case-by-case basis, whether that treatment is necessary.

The Tennessee Department of Commerce & Insurance is here to serve the consumers of Tennessee. Our Insurance Division can be a source of unbiased information and assistance to you when shopping for your insurance needs.

If you have a complaint against an insurer, it is always best to contact your insurance company first to attempt to settle the matter. Most insurance companies have policyholder service offices set up precisely to handle such questions. If you still are not satisfied, contact this department. We have complaint investigators in our Consumer Insurance Services section to assist you with your concerns. Although they cannot represent you legally against an insurance company or adjustor, they can make appropriate investigation into potential violations of insurance laws or regulations based upon your complaint.

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